

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

38608

State File No.

FILED DEC 11 1943

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County Waldron  
(b) City or town \_\_\_\_\_  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Asen. Th. Elizabeth Williams

8. (b) If veteran, \_\_\_\_\_ 8. (c) Social Security \_\_\_\_\_  
name war \_\_\_\_\_ No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife If \_\_\_\_\_  
alive \_\_\_\_\_ years

7. Birth date of deceased Oct 20 1901  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
42 1 2 hr. min.

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation Domestic

11. Industry or business \_\_\_\_\_

12. Name J. C. Kane

13. Birthplace Ill. S. O.  
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Williams

15. Birthplace Ill. S. O.  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Elizabeth Williams

(b) Address Waldron 30

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Home

18. (a) Signature of funeral director J. C. Kane

(b) Address Waldron 30

19. (a) Nov 25-43 (b) Jewell Williams  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov, day 22  
year 1943 hour 7 minute 30 P. M.

21. I hereby certify that I attended the deceased from Oct. 28  
1943, to Nov. 22 1943,  
that I last saw her alive on Nov. 22 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Thrombosis  
Due to Venus Thrombosis 25 days

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature S. M. Clark M.D. (M. D. or other)  
Address Halltown Mo. Date signed 11-24-43

PHYSICIAN

Underline the cause to which death should be charged statistically

1295 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED

Greene County Health Office,

Court File Number 43-12-122

12/9/43

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by Paul

working under my personal supervision.

Signed Walter H. ...  
C. J. ...

Licensed Embalmer No. 3270

P. O. Address ...

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

2B  
-43  
X36930

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. abc  
Registrar's No. \_\_\_\_\_

Registration District No. 320 Primary Registration District No. 5459

1. PLACE OF DEATH:

(a) County Lawrence  
(b) City or town Halltown  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Rural  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME A. Elizabeth Williams  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex 7 5. Color or race W  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Oct. 20 - 1902  
(Month) (Day) (Year)

8. AGE: Years 42 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 11-25-1943 (b) Jewell Williams  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Greene  
(c) City or town Halltown  
(If outside city or town limits, write "RURAL")  
(d) Street No. Rural Center Township  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

MOTHER, FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

38608